INDUSTRIAL MEDICAL COUNCIL

Medically Speaking

P O BOX 8888 San Francisco, CA 94128 December 1996 No. 3

Eligibility and QME process clarified

Council makes extensive revisions to QME Regulations

The Industrial Medical Council has revised its QME regulations to clarify a number of areas with respect to the eligibility of QMEs as well as the QME process itself. The changes were approved by the Office of Administrative Law and made effective on September 28, 1996.

The Council's intention is to assist claims administrators, injured workers, attorneys, physicians, Information and Assistance Officers and the Appeals Board in resolving a variety of potential areas of conflict. The QME process remains, perhaps one of the most complex areas in worker compensation practice. Parties often contact the IMC for help in resolving questions that have evolved as the QME process has broadened in scope and impact on claims before the Appeals Board. The current regulations were first enacted in 1993.

Significant changes include:

▲ clarification of QME eligibility requirements to reflect recent changes to LC § 139.2. No M.D. or D.O. who has failed a board certification exam after 1985 can be certified as a QME until the physician subsequently passes the exam.

▲ a provision allowing the claims administrator and the injured worker to agree to a specific geographic area when the injured worker has moved out of state. Section 30 (e).

▲ a procedure that allows parties to replace panel QMEs under specific circumstances. Sections 31.5 (a) and (b).

▲ procedures for requesting consultations for both window period cases (91-93) and post 1/1/94 cases. Section 32.5.

▲ procedures for obtaining rebuttal examinations for both window period cases and post 1/1/94 cases. Section 32.7.

▲ a provision that permits the claims administrator to send medical records to the QME before the 20 day time requirement in cases where the unrepresented worker makes the QME appointment immediately (or within 20 days). Formerly, the adjuster had to send the records 20 days prior to the exam even in cases where the worker made the appointment for two or three days after notice of P & S status. Non-medical information must still be showed to the injured worker prior to the exam, however. Section 35 (c).

▲ clarification of ex parte contact with QMEs. Section 35 (f).

▲ CME credit for teaching approved CME courses. Section 53 (a).

▲ clarification of QME disciplinary procedures.

▲ finally, the QME forms and notices have been simplified in some cases and information added to others.

Copies of the QME regulations have been sent to all QMEs and other interested parties may obtain copies from the IMC 1-800-794-6900 or by writing to IMC.

QME Satisfaction Survey - Continuous Quality Assurance

by Teidi Lee-Padua

Last Spring we sent out a questionnaire to 500 randomly selected active QMEs. We asked them to rate their level of satisfaction with their QME experience during the last year. We received a reasonable return response of 237 or 47% of the surveys.

The questions asked the QMEs to rate the overall quality of their QME experience from excellent to unsatisfactory. 77% rated their experience as satisfactory or better. Needless to say, we were pleased with this rating and thank you for your support and positive comments. Our goal is to provide you with the means to become an effective QME in the workers' compensation community.

The survey indicated that, for QMEs, their greatest area of concern was that they wanted to be kept up-to-date on the ever-changing workers compensation issues. In response to this major concern, we will continue to publish this newsletter periodically to keep you updated on the important issues. Like you, the IMC staff is also trying to keep up with the new regulations.

We were very surprised to learn that 92% of the respondents were not aware that the IMC had a toll free number. If you were one of them, please note that the number is: In California, 1-800-794-6900.

Again, thank you for taking the time to respond to the survey. It is important that we have this feedback so that we can meet your needs. We hope to poll a larger sample of our QME population soon.

D. Allan MacKenzie, MD, FAAOS

EMD *Viewpoint*

Although the magic moment may have passed, we should not miss the opportunity to publicly con gratulate **Drs. Marvin Lipton** and **Richard Pitts** on their reappointment to "Council" by The Governor, and to **Drs. Robert Larsen** and **Gayle Walsh** by The Senate. These terms began in October and are effective through December 1999. Congratulations!

Let me share with you my thoughts on the role of the IMC vis a vis 'The Care and Feeding of the Treating Physicians'. This arose from the AD's request that the IMC assume the task of answering questions arising from the OMFS.

Some of the Council members have stated that they feel that the IMC would be more relevant to the medical community if/as/when we are dealing with the issues of concern to the approximately 120,000 treating physicians and providers. I certainly agree with the importance and appreciate the magnitude of this task.

On 21st November, the Council addressed the question of increased involvement with the issues of the treating physicians. Since this will impact the already burdened IMC staff, we may ask for a "legislative fix" to mandate the responsibility and facilitate resource allocation.

The IMC consensus panels were convened by CPS in Sacramento on October 9, 16 and 29, 1996. They were facilitated by Dr. Lee Grutchfield and overseen by Dr. Anne Searcy and David Kizer, Esq. The meetings went smoothly and the ratings on the cervical spine and extremities were completed expeditiously. The Treatment Protocol Committee met on 11/19/96 to review these guidelines. If approved, they will be submitted for a full council vote prior to being sent out to the public for the required 15 day comment period.

Suzanne Marria, Esq. chaired the Treatment Protocol Committee meeting to review the low back consensus material. On 11/1/96, the committee completed the sections dealing with the acute and subacute evaluation and management. The section on the management of the tertiary phase has been re-drafted and reviewed by this committee on 11/19/96.

Recall that IMC staff has established a pipeline to look at medical reports selected randomly and at those kicked out by the DEU as needing constructive criticism. At the annual CHSWC meeting, I was asked for an update of that QME Report Survey presently being conducted by IMC staff.

Staff completed a 25-40 point audit on three hundred reports and then generated appropriate letters to those physicians informing them of our findings. The goal of this study is to decrease the incidence of *mediocre* reports. Following are some of the salient findings.

First the good news - 10% are pristine i.e. have no errors or shortcomings. The most frequent error is failure to report face-to-face time spent with the injured worker. The next most frequent, is failure to make the appropriate declarations/attestations such as the county where the declaration was signed or failure to include the statutes against self referral.

It is also encouraging that there is a very low incidence of serious problems such as fraud or 'bait and switch', although we have found several instances where the designated office of a panel QME was switched. These we refer to our complaint tracking crew for further investigation. Unfortunately, several reports were found to be of unacceptable quality which demanded and received redress. Finally, we hope to examine another 100 to be for a report to Casey Young by January 1, 1997.

Newsletter Staff

David A. Kizer, Esq.
Anne Searcy, M. D.
Thomas Brannon
Teidi Lee-Padua
Helen Rockwell
Jeanne Lum

This newsletter is intended as an informational and educational source for QMEs and interested persons and may be reproduced.

The 'Undress' Code

by D. Allan MacKenzie, MD, FAAOS

We all understand the term 'dress code' but what exactly is 'the *undress* code'? Further, why should this be discussed in a medical periodical directed toward QME readers? The answer is that there may be some question or confusion regarding the societal norms of propriety involved in examining a worker prior to treatment or a disability evaluation. It is my sincere hope that you not interpret this article as being patronizing.

We have received some complaints from workers who felt that their sensitivities or privacy had been unnecessarily violated during an examination. Some of the allegations have been quite serious, have led to further investigation, and may result in prosecutions.

What exactly is the problem here? We were taught as orthopedic students and residents that, after having taken a thorough history, the examiner should then do a complete physical exam. In Canada, this meant having the patient disrobe completely. Having visited orthopedic institutions across the breadth of North America, I have noted that the medical undress code remains fairly consistent.

Dr. Blair Filler has shared the following instructions given to students and residents rotating through the Orthopedic Surgery Department of The Los Angeles Orthopedic Hospital. His one disclaimer is that this does not purport to be the 'standard of care' for all orthopedic surgeons, and that not every teaching institution would necessarily agree with the following paragraphs.

Spine examinations usually require exposure of the entire spine meaning that the patient is entirely undressed and in a gown. It is recommended that all entirely undressed patients - especially those of the opposite sex - be examined in a gown, open in the back, and with a chaperon in the room.

Upper extremity examinations include exposure of the entire extremity including the neck and shoulder. Lower extremity examinations include exposure of the entire extremity including the pelvic brim to the toes.

I will not comment on the specifics of breast or rectal exams except to say that generally speaking, external genital examinations require a chaperon, particularly, when performed on a member of the opposite sex. Recall the disclaimer that this does not purport to be the 'Standard of Care'.

The Medical Board of California[1] has published the 'Garman Guidelines', originally written by Dr. Kent Garman, to help foster a circumspect environment during the performance of the physical exam. The five Garman Guidelines[2] are:

1. Allow patients to disrobe and dress in private and offer cover gowns and appropriate drapes.

2. Have one of the office staff in the room whenever possible especially during breast and pelvic exams. Dr. Garman wrote that he has spoken to many physicians who feel that this is silly and an added burden on their office staff. However, he notes, many women are offended if these exams are done without another person in attendance. Further, he believes that it would be reasonable to have your office nurse ask your patient if she (or he) would prefer to have an attendant in the room.

3. Improve your communication with the patient about the reasons for and the methods of examinations. For example, tell the patient with a hand infection, why you feel that an examination for axilliary lymphadenopathy is necessary.

4. Avoid any flirtatious behavior towards patients. He adds that since you are perceived as a 'power' figure, the patient may be hesitant to complain directly to you about jokes or other 'innocent' behavior.

5. Ask someone else to review your office procedures regarding physical examinations with a view toward avoiding any risky procedures, or making necessary changes.

Dr. Garman concludes, "Waiting for your first accusation before taking some of these simple steps is foolhardy". These guidelines were not particularly written for the Workers Compensation Community however, I believe, that they are germane and pertinent.

Good luck in your practice.

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[1] Medical Board of California Action Report, July, 1994, page 9

[2] Garman, J.K., Accusations of Sexual Misconduct or Harassment Against Physicians, MIEC Claims Alert, #16, Sept., 1994

QME, Education/Ethics Committee

by Robert Amster, MD, Chair

The QME Education/Ethics Committee of the IMC has announced changes with new IMC member Glenn Repko, joining Robert Goldberg, Alicia Abels, Gayle Walsh, Jonathan Ng and Lawrence Tain as members. Dr. Robert Amster takes over as new chair.

The committee's duties include; 1) Review continuing education program proposals, 2) Supervise administration of the QME examination and determine appropriate pass point, 3) Revise as necessary "The Physician Guide to Practice in the Workers Compensation System:, 4) Review and update Ethics Guidelines, 5) Random audit of QME reports and 6) Review of "Treating Physician Determination of Medical Issues" form.

The Committee intends to complete revision of the Physicians Guide by the end of the year and revisit the causation study.

In future columns, we will be providing updates on the Committee's progress. The Committee encourages all interested persons to participate in our public meetings and provide feedback/comments as necessary.

The Primary Treating Physician: Handle with Care (Part II)

by David A. Kizer, Esq.

Part One dealt with the change in status of the treating physician from simply treating to treating/report writing status. Part Two addresses billing issues.

Billing and payment for primary treaters reports is one of those classic mixed emotion scenarios - Someone tells you that your brand new Lexus just did a header off the Pacific Coast Highway, but your in-laws were last seen behind the wheel. If you are currently an occupational physician in the workers compensation system, there's a similar blend of satisfaction and angst that goes with the territory.

Generally, treating physicians treat their patients and eventually, in most cases, their patients improve, recover and return to work. As this process continues, the treater is obligated to complete certain functions. Within five days after undertaking treatment, the physician must submit to the claims administrator (payor) two copies of a Doctor's First Report of Injury (Form 5021) which amounts to a mini-med legal report summarizing the patient's exam, diagnosis, objective and subjective findings, medical history, treatment plan, return to work date and estimates on rehab and permanent disability. As per 8 CCR 9785 (b). The Administrative Director has determined that the treater must complete this form in addition to the Doctor's First report even though some of the information overlaps. The treater is further required to notify the payor, every 45 days or 12 visits, of the patient's progress as well as report significant changes in the patient's status such as need for surgery, permanent and stationary was reached as per, 8 CCR 9785 (c) (d).

The reports for this work are, of course, to be paid according to the Official Medical Fee Schedule. (8 Cal. Code Regs. section 9785.5(f)). This is certainly reasonable. Treaters who write brief updates of the charts to accompany the patient's visit should not be billing under the higher medical-legal fee schedule. However, as most treaters will attest, updating charts and writing a final P & S report are not always one and the same. The Legislature envisioned a comprehensive report that would allow parties to settle a claim without resorting to the QME process. The thinking was that since the physician was already familiar with the case and had access to the records this should be easy enough. The reports are presumed to be correct and admissable as evidence.

In a recent *en banc* decision, the WCAB held that the presumption of correctness of a treating physicians opinion applies to <u>all</u> medical issues not just permanent disability. <u>Minniear v. Mt. San Antonio CC 61 CCC 1055.</u>

So, why do we have billing issues arising from these reports? There are a variety of reasons. Physicians, as we have noted, are not enamored with paperwork. Most would prefer to treat and there is often a substantial amount of work and decision making in re-reviewing the charts and composing the report with conclusions on disability, rehab etc. The payors on the other hand want something specific so they can settle a case. We have already learned that physicians are remunerated under the medical fee schedule for completing these reports and for doing the routine work along with their treatment. *The question being asked is what fee schedule should the treater use if they write good reports that settle claims?*

Well, one thing is certain. If the report does happen to meet the definition of a comprehensive medical-legal evaluation, follow-up evaluation or supplement evaluation (8 Cal. Code Regs. § 9793), then the report is to be paid under the Medical-Legal fee schedule (8 Cal. Code Regs. § 9785.5(f)). To this end, Section 9793(g) defines a med-legal report as a report (1) prepared by a physician (2) obtained at the request of the parties (3) capable of proving or disproving a disputed medical fact (4) the exam it is based on was done prior to the physician getting notice that the dispute was resolved and (5) if the report is served on the employer after the dispute was resolved provided that it was served within the timeframes under IMC Reg. section 38.

Since almost all disputes are ongoing, the last two rarely come into play. Thus, in most cases if the treater meets the first three requirements, then the treating physician's billing should be paid under the medical-legal fee schedule. This allows the claims adjuster/defense attorney the flexibility to review the report to see if it actually *does* prove or disprove a disputed medical fact and allows the defense to settle the claim fairly and save further costs. In other words, this section allows the payor the ability to reward the treater who writes an excellent report which settles a claim which would otherwise be billed under the Medical Fee Schedule and take a lot longer to resolve. Since the employer's concern is getting a fair and ratable report there is certainly nothing unreasonable about this concept and, in point of fact, some payors have been taking this exact approach.

In the final analysis, employees, employers and the Appeals Board need complete and ratable reports from treating physicians. Treating physician did not ask for the additional responsibility and may be somewhat circumspect about the extra paperwork so parties should, at all times, provide adequate direction and information to them.

Acupuncturists Status Extended

The Legislature during the 1996 session amended Labor Code section 3209.3 to ex tend the sunset provision for acupuncturists to remain under the definition of "physician" until January 1, 1999. Acupuncturists will therfore remain eligible to treat injured workers and also remain eligible to become QMEs as long as they do not complete medical-legal reports on disability status.

Dealing with Work Preclusion in Psychiatric Medical-Legal Reports

by Glenn Repko, PhD

Evaluators writing medical-legal reports are some times faced with the following case:

An employee has developed a work-related psychiatric disability as a result of a traumatic experience on the job. For example there may have been a robbery at the place of employment and may be able to return to their usual and customary duties with the exception that the employee is unable to return to work at the specific office where the traumatic incident occurred. How does the evaluator deal with this situation in the report?

Unfortunately, psychiatric treatment in this case was not totally effective. The aftermath of the traumatic event left the employee with a residual disability such that the employee was unable to return to the office where the trauma occurred despite good therapeutic efforts.

In this psychiatric case, the psych medical-legal examiner would 1) declare the employee ***permanent and stationary*** when they become P & S, and 2) identify a ***work preclusion*** i.e., specifically cite that the employee is unable to return to the specific office.

When an evaluator indicates that an employee is precluded from working at a specific office, the evaluator is saying that it is their professional opinion that the employee would probably have an exacerbation of their mental condition if they are returned to work at the specific office.

Is there any permanent disability in this case? The work preclusion has a level of impairment that can be described as ***minimal***. The term minimal in a medical-legal report describes a level of impairment which causes discomfort but is not disabling. This results in no award.

How does the evaluator deal with the work impairment form in the report? The work impairment form does not specifically deal with these situations i.e. the idea of a work preclusion does not fit into any one of the 8 work function boxes. The evaluator can describe the specific work preclusion in a paragraph before or after the work impairment form. The evaluator states that the employee is precluded from working at the specific office. Assuming that the work preclusion was the only residual problem for the employee, a notation of ***no impairment*** could be put in all the 8 boxes of the work impairment form. The employee in this instance was able to return to their usual and customary duties but they just couldn't return to a specific office.

What about the issue of ***vocational rehabilitation?*** Frequently the company is accommodating and transfers the worker to another office. This work accommodation is a form of vocational rehabilitation and the employer has met its responsibility by giving the employee ***alternate work.***

What happens where the company may be too small to transfer the employee to another office? In this instance, the employee is entitled to Vocational Rehabilitation in the form of ***job placement.***

This article dealt with one specific case and outlined a discussion of issues of permanent disability and vocational rehabilitation. Other cases may have variations in the status of the employee at the time the employee becomes P & S. Remember it is the goal of the evaluator in the medical-legal report to describe as clearly as possible the situation of the employee so that judges and raters can make their determinations for the employee. The more thorough the descriptions and the more clear the report, the easier it is for the case to be successfully handled.

QME's Career of Service Spans the Continents

by Thomas E. Brannon, Senior Special Investigator

At present there are approximately 5000 QMEs providing service at 6,918 locations throughout California. Frequently IMC the reviews QME files in an effort to update their files. While doing so we encounter many QME's who have served the worker's compensation community with distinction.

One such QME is George G. Glancz, M.D., whose career documents that faith, hard work, perseverance and gentlemanly attributes merit his recognition by the IMC in this newsletter.

Dr. Glancz was born in Budapest, Hungary, two months before the Nazis occupied Budapest. The turmoil at the time placed him in hiding until 1945 when the Soviet Army liberated Budapest. He lost most of his family in the Holocaust that followed W.W.II. In 1949, his parents escaped the Communists and they went to Israel. He joined them in 1951. He finished high school in Israel and after service in the military was accepted to the Universite de Montpellier in France where he finished his pre-medical studies. He returned to Israel and received his MD degree from Tel-Aviv University.

After, finishing one year of Rotating Internship in Tel-Aviv he worked as a Doctor in the Sinai desert taking care of the Arab Bedouins where he became an accomplished camel rider.

Dr. Glancz's General Surgical Residency took place at Tufts University, Boston City Hospital in Boston, MA. He did his Orthopedic Residency at Downstate University of New York and at King's County Hospital. Dr. Glancz started his orthopedic surgery practice at Coachella Valley in July 1976, where he continues at to practice.

Dr. Glancz passed the California State Board Examination in 1975. He served on the Governing Board of JFK Hospital from 1985 to 1991 and was on the Executive Committee for three years. Capping his career he became a Fellow of the International College of Surgeons in 1987 (FICS). Dr. Glancz's QME status began on 1/1/91 and continues to present having served with distinction. This is a remarkable career for a man born during the turbulent years of aggression in World War II to not only survive but contribute so much to healing mankind. We here at IMC salute Dr. Glancz.

Public Meeting Updates

September 19, 1996
Grosvenor Hotel
South San Francisco, California

The Council meeting was called to order by Chairperson, Dr. Richard Pitts.

Dr. Allan MacKenzie gave his EMD report. In addition he gave a report of his presentation at CSHWC which was an overview of the Council's Activities for the past year. He reported that a concern was raised about the Causation Study regarding its lack of usage by the medical community. He made a commitment then to review the study and look into ways the IMC can put it to more wide term usage. Dr. Roback suggested sending out a mailing of the Causation Study.

Ms. Marria gave a report detailing actions to date on the treating guidelines which included final touches to the packet for the Consensus Panels, a working meeting on October 8th of the Treatment Guidelines committee to review the materials & make final recommendations regarding the document that will then be presented to the IMC at the October meeting.

Dr. Monosson stated that there were mixed concerns among the Council members regarding the new language at the beginning of the guidelines, so that the vote on this language will be postponed until the October meeting.

Dr. Goldberg voiced a concern that there would not be enough time for the Council to review the Committee's recommended draft of the guidelines following the October 8th meeting.

Ms. Marria assured the Council that the staff is prepared to move quickly with the work product that comes out of the October 8th meeting and distribute it to the Council so that they have 6-7 days to review it prior to the October IMC meeting.

Mr. Kizer gave a report on the neck & extremities guidelines. Tentatively the consensus panels are set up for October 9th. The Extremities mail survey was slow in getting returned so staff will follow up by fax. Areas of disagreement will be ready for the consensus panels to review.

Mr. Casey Young expressed his concern that the public be given the opportunity to see the work product that the Treatment Guidelines Committee approves following its meeting on October 8th.

Dr. Ng reported from the Disciplinary Committee of the accusations and findings regarding Dr. Chung. The Disciplinary Committee recommended that the IMC suspend Dr. Chung's QME status, pursuant to Labor Code section 139.2(m), in light of the probation imposed by the Medical Board, and to stay suspension and impose terms of probation for a time and with terms parallel to the terms of probation imposed by the Medical Board. Adjournment at 10:45 AM.

Actions Taken

1) Consent Agenda items-approved

Thursday, October 17, 1996
Embassy Suites - LAX
Los Angeles, California

The Council meeting was called to order by Chairperson, Dr. Richard Pitts.

There was some discussion on the continuing Education courses. The Council voted to approve the Orthomed course after the name of the course was changed.

Dr. Allan MacKenzie reviewed the current timeline for the treating guidelines which is intended to gain closure on this in mid-December. The Workers' Compensation community has expressed the need for an acceptable work product, stressing quality being more important than the timeline.

Mr. Kizer gave a report regarding the Cervical and Extremities Guidelines. There was a consensus meeting and the product is now ready for IMC input. The Council needs to review the text and the appropriateness levels. There will be a meeting of the Treatment Guidelines Committee on November 19th in Los Angeles to review the text and make changes. He was hopeful for a Council vote at the November 21st meeting. All comments need to go to staff prior to November 19th. After the Council votes to approve it will go through a 15 day public comment period.

October 29th is the consensus meeting in Sacramento for the Wrist guidelines. The work product will then be distributed to the Council for review. There was an opinion that the changes made were good. There was discussion regarding the issues of cost, efficiency and the cure / relieve concept.

Ms. Marria reported on the status of the Low Back Guidelines. A review was started on October 8th, but some of the consensus panel members had not finished. They now have until October 21st to complete. There will be a Committee meeting November 1st at LAX Quality Hotel 9-5 to complete. The Work product will then go to the Council prior to the November 21st meeting for review. The Committee is prepared to bring this to a vote at the November Council meeting so as to begin a 15 day public comment period. A second comment period may be necessary depending on changes. It is anticipated that staff will have our portion of the process completed at the December or January Council meeting.

Dr. Larsen commented that the Psychological Treatment Evaluation should be changed to the Psychiatric Treatment Evaluation.

Dr. Monosson recommended 4 items from the Treatment Guidelines Committee for IMC approval and moved to adopt the following:

1. Introduction Statement and Definition

2. Scope section - Dr. Monosson moved to adopt this for all guidelines. Dr. Larsen voiced concerns about repercussion and not the quality of the guidelines, that it needed a more positive goal of benefit to the patient in the statement.

The guidelines are intended to assure appropriate and necessary care of the injured workers diagnosed with these types of industrial conditions.

3. Delete the last 2 sentences in 3.2.6 EMG / NCS regarding accuracy of EMGs and physicians only.

Justification: We have no legal authority to decide who does these tests.

Dr. Monosson Moves to Delete

There was some discussion from the public that we should have the authority to decide this.

Ms. Marria gave legal counsel's view that this was a matter for the various medical boards and really a scope of practice issue outside our jurisdiction.

Dr. Jablecki wanted it in the public record that the care and management was an important issue but appropriate for another forum and agreed that it was a scope of practice issue.

Dr. Ng stated that there was a difference between scope of practice and what is appropriate care. He stated that the guidelines should be able to address appropriate training.

Dr. Leonard, Physical Medicine Specialist gave his opinion that the IMC must address what is best for the injured worker. He felt that the IMC should address who is doing the test to get the best results. He objected to the removal of the language.

Dr. Bernhard stated that he felt many physician's employed Physical Therapists to do these tests but they are being done off site and he thought this effected the quality.

Dr. Lipton stated that the market will dictate what is best, cost effective and that we cannot dictate this.

Ms. Cohn, P.T. stated we cannot dictate what types of sites medical providers perform any procedures in.

The discussion was called to a close and a vote taken.

4. CQI language - Dr. Monosson moved to Council approve the CQI language.He would like 36 months instead.

Dr. Ng questioned whether we should do this annually.

Dr. Allan MacKenzie reported that it was a serial function of the staff to scan the current medical literature for new evidence.

Dr. Ng questions whether or not we should solicit public comment.

Dr. Roback stated that he thought the public was concerned about this process and that they need to know if new information can be brought to us.

Dr. Larsen was concerned that we not create the appearance that we are doing something but really be committed to doing something.

Dr. Walsh reported that the DWC is proposing that the UR regs have an annual review so we should consider this.

Dr. Pitts felt we need a better definition of what gathering public comment means.

Dr. Susan McKenzie reported regarding the Medicode presentation last month, since Mr. Sommer was unable to attend, methodology and decision making process for selection of panel members for the 1994 CRVS and regarding the 1993 conversions.

Dr. Larsen expressed concerns regarding the methodology.

Dr. Susan McKenzie stated that there has been no decision to adopt the Medicode recommendations yet and more work will need to be done at looking at the methodology, including a general description of the methodology for assigning relative values.

Dr. Larsen asked about the general methodology for sections such as Surgery. This discussion concluded.

Dr. Pitts asked for the members of the audience form the public introduce themselves because there are new faces and it is important that we get to know one another.

Adjournment - 11:13 A.M.

Action Taken

1) Consent Agenda Items - Approved

2) Dr. Larsen moved that the "Psychological Treatment Evaluations" changed to "Psychiatric Treatment Evaluation." Approved.

3) Dr. Monosson recommended 4 items form the Treatment Guidelines Committee for adoption by the Council:

a) Introduction Statement and Definition;
b) Scope;
c) The deletion of the last two sentences in 3.2.6 EMG/NCS
d) Approval of CQI language

All items were approved.

Fee Schedule Advisory Committee Meetings

OMFS

1/16/97 1:00 - 5:00 PM
1/17/97 12:00 - 2:30 PM

MLFS

1/17/97 12:00 - 2:30 PM

Grosvenor Hotel
380 S. Airport Blvd.
SSF, CA (415) 873-3200

CME Approved Providers Update

Since our last edition of Medically Speaking.....

California Workers' Compensation Institute (CWCI)
Rea Crane, RN
120 Montgomery Street, Ste. 1300
San Francisco, CA 94104
(415) 981-2107

Industrial Claims Association (ICA)
Francie R. Lehmer, Esq.
180 Montgomery Street, Ste. 880
San Francisco, CA 94104
(415) 986-2011

Parkside Acupuncture
Jeffrey Lee, L.Ac.
2526 32nd Avenue
San Francisco, CA 94116
(415) 220-9825

Saint Francis Memorial Hospital
Gary Chan, MD
900 Hyde Street
San Francisco, CA 94109
(415) 353-6000

Notice - QMEs will be given CME credit for attending the Annual DWC Education Conference in February.

QME → Q & A

What are some of the more important things for Staff to know in scheduling QME panel cases?

1) **Address Change**. If you change your office address you must notify the IMC immediately since that will affect our computerized geographic selection process.

2) **Required Forms.**
QME Appointment Notification Form (IMC Form 12205A)
Within five (5) days of making a QME appointment, the QME must file the forms with the employee and the insurer/claims administrator. Whenever possible appointment no sooner than twenty-five (25) days from the time first contacted by the injured worker to allow the insurance carrier time to provide you the medical and/or non-medical records for the evaluation.

Qualified Medical Evaluator's Findings Summary Form (IMC Form 1002)
The completed QME's Findings Summary Form should be used as the cover sheet of the report and must accompany every copy of the report sent out.

QME Time Frame Extension Request (IMC Form 12209)
For injuries between 1/1/91 - 12/31/93, if the QME cannot complete the report within 45 days of the evaluation, a QME Time Frame Extension Request must be filed no later than the fortieth (40) day after the examination. For injuries after 1/1/94, if the report cannot be completed with 30 days, the request must be filed no later than 25 day after the examination.

The Time Frame Extension Request must be filed with the employee, the employer/claims administrator and the Executive Medical Director of the IMC.

Notice of QME Unavailability (IMC Form 12210)
If for any reason (vacation, family emergency, illness, etc.) the doctor will be unavailable to perform QME exams for at least one month, a Notice of QME Unavailability must be filed with the IMC.

3) **Interpreters**
It is the responsibility of the party producing a witness to arrange for a qualified interpreter to assist the QME in the examination. Staff should ensure the Notification Form includes an interpreter request and language spoken.

DEPARTMENT OF INDUSTRIAL RELATIONS
INDUSTRIAL MEDICAL COUNCIL
PO BOX 8888
San Francisco, CA 94128-8888

Happy Holidays from the Industrial Medical Council!!

Don't forget to serve the Summary Form on the IMC

In order to monitor the number of QME/AME reports in the compensation system, all QME's and AME's are required to serve the Findings Summary Form on the IMC (but not the QME report itself). This requirement applies to both represented and unrepresented cases.